Statewide Transformation Initiative
Involuntary Treatment Act (ITA) Review

Final Report

Submitted to

The State of Washington
Department of Social and Human Services
Health and Recovery Services Administration
Mental Health Division

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I. Executive Summary

Involuntary treatment, including civil commitment, is perhaps the most divisive and controversial topic within the mental health stakeholder community. Within Washington State, stakeholders present a broad range of strongly-held and often conflicting viewpoints – ranging from the belief that involuntary treatment should never be imposed to the view that involuntary treatment should be provided whenever mental health professionals believe that a person is in need of treatment and the person is unwilling to receive treatment voluntarily.

Primary Findings. Despite this range of opinions, however, many stakeholders share certain important beliefs about civil commitment in Washington. In particular, a broad range of stakeholder groups believe that:

- The use of involuntary treatment is not always unavoidable. The use of detention and civil commitment would decline, and lengths of stay for people who are civilly committed would decrease, if Washington State would develop effective alternatives to involuntary treatment.

- The actual statutory language of Washington's involuntary treatment laws has less impact on the use of civil commitment than other factors, especially insufficient access to community mental health services and a lack of residential crisis alternatives.

There is no "model" statute or approach to civil commitment that is implemented by a majority of States. Rather, every State has a unique set of definitions and criteria based on the State's specific policy objectives and available resources. Nonetheless, a review of statutes from a sample of comparison States suggests the following about Washington State's Involuntary Treatment Act (ITA) for adults, which is found at §71.05 of the Revised Code of Washington (RCW):

- **Definition of "mental disorder."** Washington's statutory definition of "mental disorder" is broader than that of most other States in that it is not limited to specific diagnoses or types of mental illness and does not specifically exempt certain categories of impairments such as developmental disabilities.

  Many stakeholders in Washington State – including a consensus of those serving on the Task Force providing guidance to this project – expressed concern that this broad definition results in the civil commitment of people who may not be best served in a psychiatric setting. Specifically, they noted that certain populations, such as people with dementia, traumatic brain injury, or developmental disabilities may not benefit from inpatient psychiatric treatment and might be better served in other settings.

The statutory definition of "mental disorder" could be narrowed to include only certain mental illnesses or to exclude specific conditions, such as developmental disabilities, traumatic brain injury, or dementia.

- **Definition of "gravely disabled."** Washington is among approximately half of States that permit civil commitment under a "gravely disabled" or similar standard based on the person's need for treatment as perceived by professionals or others. Washington's definition of "gravely disabled" includes a person who is experiencing severe deterioration in routine functioning, as evidenced by repeated and escalating loss of cognitive or volitional control, and who is not receiving care that is essential for their health or safety.

  This law could be amended to permit civil commitment only when a person is a danger to themselves or others and is unable to care for their essential human needs such as food and shelter. As an alternative, the law could be modified to permit civil commitment only when a person meets existing gravely disabled criteria *and* their judgment is so impaired by their mental illness that they are unable to make an informed decision about their own treatment. Another possible approach would be to permit commitment only when the person's deterioration is likely to result in their meeting other civil commitment criteria (danger to self or others) and/or hospitalization.

  Some consumers and advocates support modifying this law to narrow the grounds for civil commitment, but most stakeholders indicated that this is not as important to them as developing an effective community-based system of care that would minimize the need for involuntary treatment. Many stakeholders, including providers, family members, and prosecutors experienced with civil commitment, oppose modifications to this law.

Age of Consent for Minors. Some parents of minor children and inpatient providers have proposed changes to §71.34.500 and §71.34.530, which permit minors over 13 years to seek and receive mental health inpatient and outpatient treatment without the consent of their parents. Many States have similar laws permitting minors to access mental health and/or substance abuse treatment without the consent of their parents. The actual age of consent varies from State to State, with many States permitting minors to consent to mental health treatment and/or substance abuse treatment at the age of 16, 14, or even 12.

In Washington, concerns about the age of consent appear to be linked most directly to minors' ability to *refuse* treatment even when their parents and mental health professionals believe it is in their best interests. One option to address these concerns is to increase the age of consent to mental health treatment, but consequences of this approach may include dissuading some minors from seeking treatment. A second option would be to permit parents, in consultation with providers, to initiate treatment for minors, with a separate process to ensure that treatment is medically necessary and consistent with the minor's legal rights.

In fact, a law designed to accomplish this exists at RCW §71.34.600, but it is seldom used. Parents and providers suggested that this law is not used for a number of reasons, including that most parents are unaware of the law and providers are not clear about the rights of minors under the law and how minors can access the legal system if they object to treatment. More research is needed to better understand why parent-initiated treatment is not used before more sweeping options, such as increasing the age of consent, are considered.

Other Issues Outside the Scope of This Study. Stakeholders expressed several additional concerns related to the ITA that are outside the scope of the current review. The most important of these is the statutory procedure for the involuntary administration of psychotropic medications, which a broad range of stakeholders agree should be examined and possibly reformed.

Before implementing any changes to the ITA or other involuntary treatment laws, Washington should consult with and carefully consider implications for consumers and other service systems, including criminal justice, developmental disabilities, aging, and long term care.

II. Introduction

The Washington Department of Social and Health Services (DSHS) Mental Health Division (MHD) has engaged TriWest Group (TriWest) to conduct a review of the Involuntary Treatment Act (ITA) in Washington State. Specifically, TriWest was asked to perform the following tasks:

- Review specific provisions in State involuntary treatment statutes;
- Compare specific provisions with other States' approaches; and
- Identify strengths, challenges, and options for reform.

TriWest Group partnered with Advocates for Human Potential, Inc. (AHP) to conduct primary research and initiate development of reports under this project, including this Final Report.

A. Project Overview

The ITA review is being conducted in connection with four other initiatives as part of an overall Strategic Transformation Initiative (STI) being led by MHD. Other components of the STI include:

- Funding for Programs of Assertive Community Treatment (PACT), including training and technical assistance to support implementation;
- Review of Washington's benefits package for adults and children with mental disorders;
- Development of a mental health housing plan; and
- Development of an inpatient utilization review protocol.

MHD appointed a multi-stakeholder Task Force to provide input on STI activities, including the ITA review.

B. Research Methods

Research methods employed in the development of this preliminary report include: (1) general literature review and legal research regarding the evolution of State civil commitment laws, noting implications for hospital utilization; (2) periodic solicitation of input from the Task Force regarding the scope and focus of the project as well as specific recommendations for reform; (3) extensive use of key informant interviews, including national experts and stakeholders within Washington State; (4) use of focus groups to explore additional detail in particular areas of concern; and (5) solicitation of input at two large, multi-stakeholder Community Forums.

Participants in one Community Forum, held May 15, 2007 in Seattle, used Audience Response System technology to register their perspectives or concerns in specific topic areas. Their responses to questions regarding the ITA review are described in more detail throughout this report.

Appendix A includes a list of key informants interviewed for this review, as well as the names of focus group participants.

C. Project Scope

In guiding TriWest/AHP's work in connection with this project, MHD emphasized that the ITA review is driven, in significant part, by the following policy objectives: (1) to create a recovery-focused, resiliency-based system of care in the community; and (2) to ensure that utilization of inpatient services is necessary and appropriate. The analysis presented in this preliminary report is grounded in these important policy objectives.

The term "involuntary treatment" is very broad, and could be interpreted to mean involuntary outpatient commitment (also called "assisted treatment" by some advocates), involuntary medications, or other interventions deemed by consumers to be coercive. For the purposes of this review, the discussion of "involuntary treatment" will focus principally on inpatient civil commitment.

A critical issue to be examined in this report, which emerged from discussions with the STI Task Force and other stakeholder meetings, is the definition of "mental disorder" in the statute. In addition, MHD staff directed TriWest/AHP to focus its review on the following issues:

- Definition of "grave disability" in Washington's civil commitment statute; and
- Washington's "age of consent" for receiving mental health services, including a review of the law permitting parent-initiated treatment.

Forensic laws regarding the treatment of people with mental illness in the criminal justice system fall outside the scope of this review. However, preparation of this report did include some background research, meetings, and key informant interviews regarding a few specific areas of concern, including: (1) Washington's law requiring mandatory detention under the civil commitment laws of certain misdemeanants found not competent to stand trial ("forensic conversion"); (2) contents of required forensic evaluation reports; (3) location of competency restoration efforts for midemeanants; and (4) competency process for juveniles. A brief overview of these issues is presented in Section VII of this report.

Additional issues that were identified by several stakeholders or the authors as priorities for review are discussed briefly in Section IX of this report, although a thorough analysis of these issues falls outside the scope of this report.

III. Background and Context for Review

Involuntary treatment, including civil commitment, is perhaps the most divisive and controversial topic within the mental health stakeholder community. In the course of this review, the authors considered a broad range of strongly-held and often conflicting viewpoints regarding civil commitment. For example, members of the STI Task Force's ITA Focus Group were asked to articulate, from their perspectives, the most important policy objectives or desired outcomes for reforms to Washington State's involuntary treatment laws. Their responses included:

Make civil commitment more available as a mechanism to divert people who will otherwise be involved in the criminal justice system	*and*	Narrow civil commitment laws to ensure that everyone who is civilly committed can benefit from hospitalization
Lower the threshold for commitment under the grave disability standard to make getting help easier	*and*	Raise the threshold for commitment under the grave disability standard to promote civil rights and minimize the use of inpatient services

Even within specific stakeholder groups, perspectives on involuntary treatment often vary. For example, many consumers participating in the Community Forum, Task Force, and other focus groups in connection with this review expressed a concern that involuntary treatment is traumatic, does not support recovery, and violates an individual's rights to liberty. Some shared personal stories that questioned whether civil commitment was appropriate in their case or whether the process used was fair. Other consumers interviewed for this review suggested that they benefited from involuntary treatment. One person, who was committed at Western State Hospital at the time of the interview, summarized the tension well, stating that he does not support the "gravely disabled" criteria under which he was committed, but added that his hospitalization resulted in a new treatment approach that will be beneficial to him in the community and help him to avoid interactions with the criminal justice system.

Stakeholders also share certain beliefs regarding the multiple, sometimes competing policy objectives underlying involuntary treatment. At the May 15 Community Forum (described in Section II, above), stakeholders were asked to rank, on a scale of 1-5, the importance of five specific policy objectives. These objectives, and the rankings attributed to each, follow:

- Ensuring that individuals receive mental health treatment that they need (4.6)
- Ensuring that parents can access needed mental health services for children and adolescents (4.2)
- Ensuring public safety (4.2)
- Diverting individuals from the criminal justice system and homelessness (3.9)
- Protecting individual civil liberties (3.9)

There were some differences among stakeholder groups in ranking potential policy objectives. For example, people who said they primarily represented consumers were much more likely to feel that protecting civil liberties was "very important" than were other stakeholders (70 percent as opposed to 37 percent). However, only a small number of stakeholders thought that any of the potential policy objectives were "not at all important" or "not important."

Stakeholders also share certain important beliefs about civil commitment in Washington: In particular, there is a general consensus that:

(1) The use of involuntary treatment is not always unavoidable. The use of detention and civil commitment would decline, and lengths of stay for people who are civilly committed would decrease, if Washington State would develop effective alternatives to involuntary treatment.

At the May 15 Community Forum, 74 percent of the 128 stakeholders responding said they agreed or strongly agreed with the following statement:

> The use of civil commitment too often reflects a lack of sufficient appropriate, recovery-oriented community services, and that developing these services would lead to an overall decline in the need for civil commitment.

Only 12 percent of stakeholders responding said they disagreed or strongly disagreed with that statement.

(2) The actual statutory language of Washington's involuntary treatment laws has less impact on the use of civil commitment than other factors, especially insufficient access to community mental health services and a lack of residential crisis alternatives.

Stakeholders at the May 15 Community Forum were given a list of 10 potential factors affecting the use of civil commitment in Washington State and asked to rank the top three. Among these stakeholders the actual statutory language and even the application of the law by Designated Mental Health Professionals (DMHPs) and courts were not considered to be as important in determining when civil commitment is used as the availability and accessibility of key services. These views are consistent with feedback received from stakeholders throughout the process of researching this report.

The following list ranks the 10 potential factors in the order provided by stakeholders at the May 15 Community Forum:

1. Insufficient access to mental health services (eligibility and availability)
2. Lack of residential crisis alternatives
3. Insufficient access to services, like PACT, for people with the most severe illnesses who have not benefited from traditional services
4. Insufficient access to mental health services that consumers *want*
5. Lack of housing and other community residential options
6. Lack of specialized community services for special populations
7. Subjective interpretations of the law by DMHPs
8. Reaction by DMHPs and courts to high-profile incidents
9. Actual language used in the ITA statute
10. Lack of employment options

A. Evolution of Commitment Criteria

Until the 1960s and 70s, most States permitted involuntary hospitalization based on a perceived need by clinicians and professionals that the individual needed treatment. During the 1970s, several Federal court decisions helped to spur a narrowing of most State laws to require dangerousness as a condition for involuntary hospitalizations.[1] In 1973, following a decision by the Washington Supreme Court that the State must prove by clear, convincing, and cogent evidence that a person is mentally ill and dangerous,[2] Washington enacted legislation permitting involuntary commitment only if a person (1) poses a likelihood of serious harm to himself or others; or (2) is gravely disabled. That legislation defined "gravely disabled" as a condition in which a person, as a result of a mental disorder, is "in danger of serious physical harm resulting from a failure to provide for his essential human needs of health or safety."[3]

Some Washington stakeholders were dissatisfied with the new law. In particular, family members said they were forced to abandon loved ones in order to meet the standard that the person being committed is unable to meet "essential human needs" such as food and shelter.[4] Some providers also expressed frustration at their inability to obtain

[1] Miller, R.D., Involuntary Civil Commitment, in American Psychiatric Press, Review of Clinical Psychiatry and the Law, vol. 2, Simon, R.I. (editor) (1991). *See especially* Lessard v. Schmidt, 349 F. Supp. 1078, 1085-86 (E.D. Wis. 1972), *vacated and remanded for a more specific order*, 414 U.S. 473 (1974), *order on remand*, 379 F. Supp. 1376 (E..D. Wis. 1974), *vacated and remanded on other grounds*, 421 U.S. 957 (1975), *order reinstated on remand*, 413 F. Supp. 1318 (E.D. Wis. 1976).

[2] In re Levias, 83 Wn. 2d 253, 517 P.2d 588 (1973). For a brief history of involuntary commitment in Washington State through 1984, see Drumheller, B.L., *Constitutionalizing Civil Commitment: Another Attempt – In Re Harris*, 59 Wash. L.Rev. 375 (April, 1984).

[3] Drumheller, B.L. (1984). *Constitutionalizing Civil Commitment: Another Attempt – In Re Harris, 98 WN.2d 276, 654 P.2d 109 (1982)*. 59 Wash. L. Rev. 375.

[4] Pierce, G.L., Durham, M.L. and Fisher, W.H. (1985). The Impact of Broadened Civil Commitment Standards on Admissions to State Mental Hospitals. 142 Am J. Psychiatry at 104-107.

commitment for people that they believed were in need of treatment but who were still able to meet essential human needs.[5]

In 1979, following a highly publicized double murder by a person with a mental illness, Washington became one of the first States to expand its definition of "gravely disabled" to include a criterion based on mental – not just physical – deterioration and a need for treatment.[6] Washington's definition of "gravely disabled" now includes a person who "manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety." Today, about half the States have a similar "need for treatment" criterion for civil commitment, although specific definitions and requirements vary from State to State.[7]

Washington's civil commitment statute (or ITA) is provided at RCW §71.05.

B. Civil Commitment Processes

Civil commitment processes are unique to every State but most – including Washington – permit a brief period of initial detention without a court hearing. Subsequent detentions generally require a court hearing, with substantial due process protections for the person who is the subject of the commitment petition. A brief summary of Washington's civil commitment process is attached to this report as Appendix B.

In general, Washington stakeholders seem satisfied with the commitment process provided in the statute. However, some stakeholders suggested that the process is not always applied as it is articulated in the law. In particular, consumers suggest that, although the statute clearly provides individuals with the right to participate in their commitment hearings, many are not informed of that right or are discouraged from participating. In addition, providers and consumers point out that the timeframes described in the statute often are extended, at least in part because appropriate placements either in the community or the State hospital are not available.

C. Less Restrictive Alternatives

Like most States, Washington requires that less restrictive alternatives (LRAs) be considered before an individual may be civilly committed to an inpatient setting.[8] However, most courts across the country that have considered this issue agree that this requirement is applicable only where the services are available.[9] In the landmark case Olmstead v. L.C., the U.S. Supreme Court considered a related question: Does the Americans with Disabilities Act (ADA) require States to provide services to people with

[5] Id.
[6] The new law also restored "danger to property" as a component of the "likelihood of serious harm" criteria for commitment. Id. This provision is discussed briefly in Section IX of this report.
[7] See Treatment Advocacy Center, *State Standards for Assisted Treatment*, at www.psychlaws.org.
[8] Levy, R.M. and Rubenstien, L.S. (1996). The Rights of People with Mental Disabilities (ACLU Handbook) at 33. Southern Illinois University Press: Carbondale and Edwardsville.
[9] Id.

disabilities – including people with mental illnesses – in the most integrated setting appropriate for their needs? The Supreme Court's response was a qualified yes – services should be provided in the most integrated setting, but a State is not required to create new services to accomplish this.[10]

Some stakeholders in Washington State suggested that not all judges are aware of the range of LRAs that may be available, and that LRAs should be used more frequently.

[10] Olmstead v. L.C., 527 U.S. 581 (1999).

IV. Data Review

As background for this preliminary report, this section briefly discusses Washington's utilization of inpatient facilities relative to other States, State mental health authority spending on inpatient services relative to other States, variation in commitment rates across RSNs, and a discussion of the impact that the broadening of the "gravely disabled" standard in 1979 had on commitment rates.

A. Inpatient Utilization

An important impetus for the ITA review is a general concern regarding appropriate utilization of inpatient psychiatric services. According to data collected by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) through its Uniform Reporting System (URS) in 2004, Washington's State hospital utilization rate is .57 per 1,000 people in the State – slightly lower than the national rate of .61 per 1,000 people. However, Washington's community inpatient admission rate is 1.03 – significantly higher than the national rate of .61 per 1,000 people.

Since the URS data were collected in 2004, Washington has added State hospital beds. However, no data is available to demonstrate the impact of those beds on the overall utilization rate in either State or community hospitals.

B. Inpatient Expenditures

The National Association of State Mental Health Program Directors (NASMHPD) Research Institute, Inc. collects data annually regarding State mental health agency revenues and expenditures. In 2004, the most recent year for which national data are available, Washington ranked 21st in per capita spending by State mental health agencies on State hospitals – spending $27.81 per capita as compared to the national median of $26.72. However, Washington's per capita spending was slightly lower than the national average (mean) of $29.51, which reflects very high spending by the District of Columbia and a few other States.

As a percentage of overall mental health spending, Washington's State hospital expenditures are lower than the national average. In 2004, Washington spent 29 percent of overall mental health expenditures in State hospitals, as compared to the national average of 32 percent.[11]

C. Detention Rates and Variation across RSNs

A broad range of stakeholders – including providers, family members, and consumers -- identified variation among RSNs as a principal concern related to the ITA. In particular, some stakeholders suggested that Designated Mental Health Professionals (DMHPs) –

[11] Id.

professionals employed by the RSN and charged with the responsibility of carrying out assessments for initial detentions under the ITA – in King County RSN interpreted civil commitment criteria very narrowly and were much less likely than their counterparts in other RSNs to initiate an initial detention.

Representatives from King County RSN and the State association representing DMHPs dispute that hypothesis, citing a 1999 study of DMHPs across the State, which found that perceptions of King County DMHPs[12] regarding whether an individual has met commitment criteria in a particular case generally match those of DMHPs in other counties.[13] However, nearly all stakeholders agree that the defense bar in King County is more aggressive in defending against civil commitments than in other regions of the State, possibly leading to reluctance by DMHPs to initiate initial detentions and by prosecutors to pursue 14-day and 90-day commitments.

Although the State collects data from RSNs regarding rates of initial detentions, many stakeholders questioned the accuracy of the State's data and, as a result, they are not presented here. However, a review of the available data suggests that detention rates do vary considerably across RSNs, and population and/or geographic location do not appear to account entirely for the variation.

It is important to note that whether or not civil commitment criteria are applied more narrowly in any given RSN, the mere *perception* that this is the case may actually have an important impact. In particular, the belief that a civil commitment order is hard to obtain may lead to police officers and prosecutors pursuing criminal charges in misdemeanor cases in order to detain a person who they believe needs evaluation or treatment.

D. Impact of 1979 Law

Following Washington's adoption in 1979 of broader criteria for civil commitment under the gravely disabled standard, Pierce, Durham, and Fisher reviewed the number of civil commitments and concluded that involuntary admissions to the State hospital nearly doubled in the year following enactment of the new law.[14] This study frequently is cited as evidence that a broadening of commitment criteria will result in an increase in the utilization of inpatient services.

However, the authors of that study also noted that the *total* number of admissions to State hospitals – both voluntary and involuntary – during that time increased by only about 30 percent.[15] Since the patient characteristics of people who were civilly committed did not change under the new law, the authors concluded that the most significant impact of the

[12] Until 2005, DMHPs were employed by counties and were known as County Designated Mental Health Professionals, or CDMHPs.
[13] Fine, D. and Bell, M. (1999). King County Review of Standards for Detention. Unpublished document obtained from Amnon Shoenfeld, King County RSN.
[14] Pierce, G.L., Durham, M.L. and Fisher, W.H. (1985). The Impact of Broadened Civil Commitment Standards on Admissions to State Mental Hospitals. 142 Am J. Psychiatry at 104-107.
[15] Id. at Table 1.

law was to "involuntarize" the process of admission for many people who might otherwise have been admitted voluntarily.

It seems logical to assume a change in inpatient utilization when a statute is altered, since the purposes of expanding or narrowing criteria generally include affecting the number and range of people who can be committed. However, the experience of Washington and some other States suggests that the actual application of civil commitment laws may depend not only on the language of the statute but also on other factors, such as the availability of housing and community services, aggressiveness of prosecutors and defense attorneys, and expectations of community members regarding non-conforming behavior.

In research published after the Pierce, Durham, and Fisher study, Miller observed that the steep increase in commitments began several months *before* the statute went into effect, suggesting that the increase in involuntary commitments may have been principally a reaction to the highly-publicized double murder rather than the change in the definition of "gravely disabled."[16] Miller reviewed data from seven other States that had adopted broader commitment statutes. He concluded that only two of those States experienced significant increases following the adoption of the new standards, and he offered alternative theories for those increases. In particular, he noted that the broadening of commitment criteria generally follows a high-profile tragedy or crime – as was the case in Washington – which often results in increases in civil commitment rates regardless of any change in statutory criteria.

These studies examine the impact of legislation broadening civil commitment criteria, with conflicting conclusions regarding the impact of these changes on inpatient utilization. We are not aware of any efforts to review the impact of legislation that narrows – rather than broadens – criteria for civil commitment. While it seems reasonable to expect that such a change would result in a decrease in civil commitments, the considerable variation that currently exists among States applying similar commitment criteria suggests that the outcome may be more complicated or nuanced.

[16] Id. at 1381.

V. Key Issues and Analysis

This section provides a discussion of two key provisions of the ITA identified by MHD and multiple stakeholders as priorities for review: (1) the definition of "mental disorder"; and (2) the definition of "gravely disabled". Each of these subsections includes an overview and analysis of the statutory text, a summary of stakeholder concerns, a comparison to other States' approaches, and a discussion of specific options for reform. In addition, a separate subsection describes stakeholder concerns related to possible reform, implications for other service systems, and possible approaches to addressing these concerns.

Comparison States were selected in collaboration with MHD on the basis of two principal factors: (1) geographic similarities, especially States with large rural areas and a few urban centers; and (2) similar financing structures. The comparison States are Arizona, Colorado, Iowa, Massachusetts, New Mexico, and Oregon.

A. Definition of "Mental Disorder"

Overview of Issue

Washington's statute defines "mental disorder" as "any organic, mental, or emotional impairment which has substantial adverse effects on a person's cognitive or volitional functions."[17] Although MHD did not initially direct TriWest/AHP to review this specific provision, stakeholders participating in Task Force meetings and key informant interviews repeatedly identified this definition as one of their most important concerns. As a result, MHD agreed that it should be a focus of review.

Specifically, the broad definition of "mental disorder" in the statute encompasses many people who may not have psychiatric illnesses, such as people with developmental disabilities, dementia, or traumatic brain injury (TBI). Nearly all members of the STI Task Force agreed that this may lead to the civil commitment of people who are not best served in psychiatric hospitals, and many expressed a particular concern that Washington State hospitals have become providers of last resort for these hard-to-serve populations.

However, a broader range of stakeholders were divided on this issue. At the May 15 Community Forum, stakeholders were asked to rate their level of agreement with the following statement:

> In my opinion, the definition of "mental disorder" in Washington State is too broad, resulting in detention and civil commitment of people who are not best served in an inpatient psychiatric setting.

Of the 124 responses, 29 percent strongly agreed with that statement, while 27 percent strongly disagreed. The responses are summarized at Figure 1 below:

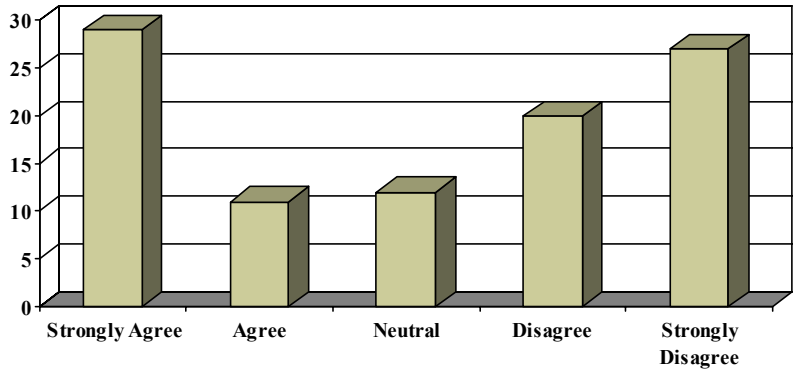
[17] RCW §71.05.020(22).

Figure 1.

May 15 Community Forum Audience Response System:

On a scale of 1-5, rate your level of agreement with the following statement:

> In my opinion, the definition of "mental disorder" in Washington State is too broad, resulting in detention and civil commitment of people who are not best served in an inpatient psychiatric



Analysis

Defining "mental disorder" in the context of civil commitment is a policy issue, rather than a legal or medical issue. Many States use the term "mental disability" rather than "mental disorder," and it may refer to a comprehensive range of impairments that affect mental or cognitive functioning, including mental illnesses, developmental disabilities, cognitive communication disorders, and substance abuse.[18] The DSM-IV uses the term "mental disorders" to include mental illnesses as well as mental retardation and various substance abuse disorders. The DSM-IV acknowledges:[19]

> [T]hat no definition adequately specifies precise boundaries for the concept of a "mental disorder." The concept of mental disorder, like many other concepts in medicine and science, lacks a consistent operational definition that covers all situations ….

There is no model statutory definition or consistent approach used across States. In fact, every State defines the population of people who may be civilly committed differently through both the language of their statute and case law interpreting it. In general, "mental disorder," "mental disability," or even "mental illness" are likely to be defined in

[18] Parry, J. (1995). Mental Disability Law: A Primer, at 2-3. American Bar Association Commission on Mental and Physical Disability Law: Washington DC.
[19] Id., *citing* Diagnostic and Statistical Manual (DSM) IV.

order to achieve specific policy objectives and to reflect policy decisions regarding the appropriate locus of services for people with specific mental or cognitive disabilities.

The following table summarizes the range of approaches to defining mental disorder in the comparison States. Four of the six States explicitly exclude people with developmental disabilities, to some extent, from their definitions.

Figure 2.

State Approaches to Defining Mental Disorder/Mental Illness in Civil Commitment Laws	
Arizona	"Mental disorder" means "a substantial disorder of the person's emotional processes, thought, cognition or memory. Mental disorder is distinguished from: (a) Conditions that are primarily those of drug abuse, alcoholism or mental retardation, unless, in addition to one or more of these conditions, the person has a mental disorder. (b) The declining mental abilities that directly accompany impending death. (c) Character and personality disorders characterized by lifelong and deeply ingrained antisocial behavior patterns, including sexual behaviors that are abnormal and prohibited by statute unless the behavior results from a mental disorder." *Ariz. Rev. Stat. §36-501(26).*
Colorado	"Person with a mental illness" means "a person with one or more substantial disorders of the cognitive, volitional, or emotional processes that grossly impairs judgment or capacity to recognize reality or to control behavior. Developmental disability is insufficient to either justify or exclude a finding of mental illness within the provisions of this article." *Colo. Rev. Stat. 27-10-102(8.5)*
Iowa	"Mental illness" means "every type of mental disease or mental disorder, except that it does not refer to mental retardation … [as defined elsewhere in the Iowa Code] or to insanity, diminished responsibility, or mental incompetency as the terms are defined and used in the Iowa criminal code …." *Iowa Code 229.1(9).*
Massachusetts	Statute requires a mental illness, but does not provide a statutory definition. *See Mass Gen. Laws ch. 123.*
New Mexico	"Mental disorder" means "the substantial disorder of the person's emotional processes, thought or cognition which grossly impairs judgment, behavior or capacity to recognize reality, but does not mean developmental disability." *N.M. Stat. Ann. 43-1-3(O).*
Oregon	"Mentally ill person" means a person who, because of a mental disorder, is one or more of the following: (A) Dangerous to self or others. (B) Unable to provide for basic personal needs and is not receiving such care as is necessary for health or safety. (C) A person who: (i) Is chronically mentally ill ….; (ii) Within the previous three years, has twice been placed in a hospital or approved inpatient facility by the department …; (iii) Is exhibiting symptoms or behavior substantially similar to those that preceded and led to one or more of the hospitalizations or inpatient placements …; and (iv) Unless treated, will continue, to a reasonable medical probability, to physically or mentally deteriorate so that the person will [become a danger to themselves or others or be unable to provide for their basic personal needs]." *Or. Rev. Stat. § 426.005(1)(d).* Mental disorder is not defined in the statute.

Strengths

The breadth of the definition of "mental disorder" in Washington's civil commitment law provides flexibility for DMHPs, prosecutors, and others to ensure that people can be ordered for evaluation and treatment when necessary, regardless of specific diagnosis.

Challenges

The flexibility that could be considered a strength of Washington's definition of "mental disorder" may result in civilly committing to inpatient psychiatric services many people who cannot benefit from the treatment provided there. Very broad statutory language permits hospitals – especially State hospitals, but also to some degree community providers of psychiatric inpatient services – to become providers of last resort even when that approach is neither effective nor efficient. Once hospitalized, the ability to discharge the person to another setting is compromised by the inability of the facility to actively treat or otherwise affect the course of the disorder. Although specific, relevant data were not made available to the authors for this report, anecdotal evidence suggests that many people with developmental disabilities in Washington State hospitals may have longer lengths of stay, further contributing to the concern that inpatient services in the State may be over-utilized.

To the extent that the definition of "mental disorder" contributes to inpatient hospitalization of people who cannot benefit from treatment and face significant obstacles to discharge, it undermines MHD's goal of creating a recovery-focused system of care that emphasizes community services where possible.

Options for Reform

There are a broad range of potential approaches to reforming Washington's statute to prevent the civil commitment of people who are not likely to benefit from the treatment available to them in inpatient psychiatric settings. All of them likely would put pressure on other service systems, and should be considered in the context of a broader strategy to meet the needs of people who would no longer be eligible for commitment under the statute. Ideally, that strategy would focus on providing effective and likely less expensive services in the community to minimize the need for institutionalization, whether voluntary or involuntary. However, a few stakeholders expressed the need for the State to create a secure facility for people with developmental disabilities who may pose a danger to themselves or others and who would otherwise be committed to State hospitals.

If a change to the statutory definition of "mental disorder" is considered, more information is needed regarding the actual diagnoses of people who are initially detained and/or civilly committed for long periods of time and their lengths of stay in order to tailor the statutory language to address the specific populations for which civil

commitment may be over-used or inappropriate. Two possible approaches to revising the statute are presented here.

1. **Change "mental disorder" to "mental illness" and define mental illness more narrowly.** Although neither term has a precise legal definition, some States permit civil commitment only for people with mental illnesses and attempt to define that in more narrow, clinical terms. For example, Pennsylvania defines mental illness as those "disorders that are listed in the applicable APA Diagnostic and Statistical Manual." Pennsylvania goes on to exclude some DSM diagnoses from the definition unless they co-occur with other qualifying conditions: "[P]rovided however, that mental retardation, alcoholism, drug dependence and senility do not, in and of themselves, constitute mental illness. The presence of these conditions however, does not preclude mental illness."

2. **Specifically exclude people with developmental disabilities or other conditions from the definition of "mental disorder."** Like Pennsylvania, several States make such an exclusion explicit in their statutes. For example, New Mexico has a fairly broad definition of "mental disorder" but specifically provides that mental disorder "does not mean developmental disability."

   Arizona's statute provides a useful approach to excluding a range of conditions from the definition of mental disorder while addressing the possibility that some of these conditions may co-occur with conditions that do meet the statutory definition:

> Mental disorder means a substantial disorder of the person's emotional processes, thought, cognition or memory. Mental disorder is distinguished from:
>
> (a) Conditions that are primarily those of drug abuse, alcoholism or mental retardation, unless, in addition to one or more of these conditions, the person has a mental disorder.
> (b) The declining mental abilities that directly accompany impending death.
> (c) Character and personality disorders characterized by lifelong and deeply ingrained antisocial behavior patterns, including sexual behaviors that are abnormal and prohibited by statute unless the behavior results from a mental disorder.

Washington's own statute governing mental health services for minors also limits the range of conditions considered to be a "mental disorder." The statutory definition mirrors the language in §71.05 but goes on to provide that: "The presence of alcohol abuse, drug abuse, juvenile criminal history, antisocial behavior, or mental retardation alone is insufficient to justify a finding of "mental disorder" within the meaning of this section."[20]

B. Definition of "Gravely Disabled"

Overview of Issue

All States permit the involuntary civil commitment of people with mental illnesses who pose a danger to themselves or others, and most also permit the commitment of people who are so "gravely disabled" by their illness that they are unable to meet essential human needs. As discussed in Section III above, following a national trend toward more restrictive civil commitment laws, Washington was one of the first States to expand its definition of "gravely disabled" to permit the civil commitment of a person who is experiencing a physical or mental deterioration in functioning that threatens the person's health or safety, even if the person's essential needs such as food and shelter are met. Washington's statute defines "gravely disabled" as the following:[21]

> [A] condition in which a person, as a result of a mental disorder: (a) Is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety; or (b) manifests severe deterioration in routine functioning evidence by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety.

About 62 percent of the total number of people reported to be detained under the involuntary treatment laws in Washington State during FY2006 were considered to be

[20] RCW §71.34.020(13).
[21] RCW §71.05.020(16)

"gravely disabled."[22] It is not clear from available data how many of these individuals may also have been considered committable on the grounds that they also posed a danger to themselves or others, as more than one reason was provided for as many as 1,100 of the detentions recorded.[23]

Stakeholder views on Washington's definition of "gravely disabled" vary significantly, and often reflect the stakeholder's broader views on the efficacy and ethics of all forms of involuntary treatment. Most consumers consulted in the initial research for this project felt that the current definition is too broad, and several provided the authors with examples of instances in which they felt it was used inappropriately. For example, one person currently committed to Western State Hospital said he believed that he was committed principally because he was homeless and expressed the fear that he would again be either arrested or detained under the civil commitment law because he did not have a stable home. Concerns about the inappropriate use of the "gravely disabled" criteria as a means of civilly committing people who are homeless or lack other resources also were echoed by defense attorneys and the State's protection and advocacy agency.

Family members, on the other hand, said that even the broad definition in current law makes civil commitment of loved ones too difficult. At the May 15 Community Forum, stakeholders were asked to rate their level of agreement with the following statement:

> In my opinion, the definition of "gravely disabled" in Washington State is too broad, resulting in the over-use of detention, civil commitment, and inpatient services.

Nearly half of the stakeholders responding said they strongly disagreed with this statement and two-thirds said they either disagreed or strongly disagreed. These responses suggest that reform proposals that would narrow the definition would face strong opposition within the State. The responses are summarized at Figure 3 below:

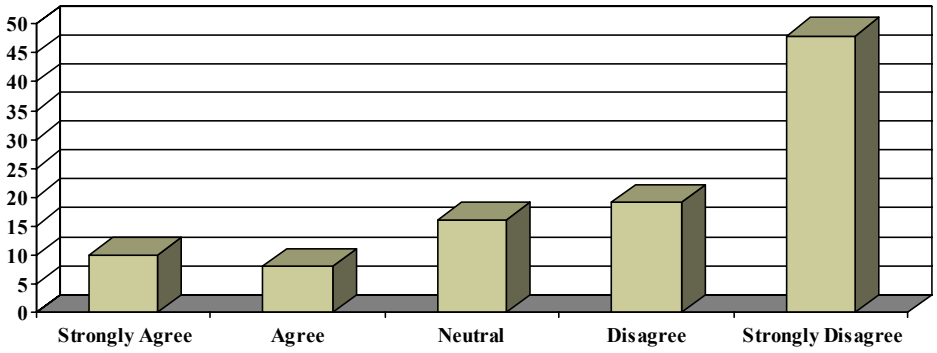
[22] Data provided by DSHS MHD (e-mail correspondence from Judy Hall, dated 1/25/07).
[23] Data collected by MHD provide 7,747 reasons for the total 6,586 72-hour detentions reported in 2006.

Figure 3.

May 15 Community Forum Audience Response System:

On a scale of 1-5, rate your level of agreement with the following statement:

In my opinion, the definition of "gravely disabled" in Washington State is too broad, resulting in the over-use of detention, civil commitment, and inpatient services.



In focus groups and key informant interviews, most stakeholders said that they believe that the language of the statute is less important than how it is applied, and many suggested that variability among counties and RSNs be studied and addressed. Nearly all stakeholders agreed that the most important "reform" the State should implement is to provide effective, recovery-oriented, and resiliency-based services in the community to minimize, if not eliminate, the need for civil commitment and other forms of involuntary treatment. As indicated in Section III, above, most stakeholders believe that, if such a community-based system were in place, detention and civil commitment would be used less frequently regardless of the specific language in the statute.

Analysis

Most States permit civil commitment for individuals who are considered to be "gravely disabled," although many States use a different term or simply embed the criteria in other definitions. As discussed above, there is no "model" statutory definition or consistent approach used across States, so a review of any law should consider whether it is effective in achieving a given State's policy objectives.

The following table summarizes the range of approaches used to define "gravely disabled" or similar civil commitment criteria in the comparison States:

Figure 4.

State Approaches to Defining Gravely Disabled in Civil Commitment Laws	
Arizona	"Gravely disabled" means "a condition evidenced by behavior in which a person, as a result of a mental disorder, is likely to come to serious physical harm or serious illness because he is unable to provide for his basic physical needs." *Ariz. Rev. Stat. §36-501 (16).* In addition, "persistently or acutely disabled" means "a severe mental disorder that meets all of the following criteria: (a) If not treated has a substantial probability of causing the person to suffer or continue to suffer severe and abnormal mental, emotional or physical harm that significantly impairs judgment, reason, behavior, or capacity to recognize reality. (b) Substantially impairs the person's capacity to make an informed decision regarding treatment and this impairment causes the person to be incapable of understanding and expressing an understanding of the advantages and disadvantages of accepting treatment and understanding and expressing an understanding of the alternatives to the particular treatment offered after the advantages, disadvantages and alternatives are explained to that person. (c) Has a reasonable prospect of being treatable by outpatient, inpatient or combined inpatient and outpatient treatment. *Ariz. Rev. Stat. §36-501(33).*
Colorado	"Gravely disabled" means "a condition in which a person, as a result of a mental illness: (I) Is in danger of serious physical harm due to his or her inability or failure to provide himself or herself with the essential human needs of food, clothing, shelter, and medical care; or (II) Lacks judgment in the management of his or her resources and in the conduct of his or her social relations to the extent that his or her health or safety is significantly endangered and lacks the capacity to understand that this is so. *Colo. Rev. Stat. 27-10-102(5)(a).* The statute specifically permits a finding of gravely disabled where a person is not in danger of harm because of care provided by a family member if there is notice that the support is to be terminated and the individual meets several additional criteria, including treatment for specific diagnoses of mental illness and/or recent, repeated hospitalizations. *Colo. Rev. State. 27-10-102(5)(b).*
Iowa	No specific "gravely disabled" provision, but "seriously mentally impaired" means "the condition of a person with mental illness and because of that illness lacks sufficient judgment to make responsible decisions with respect to the person's hospitalization or treatment, and who because of that illness meets any of the following criteria: … (c) Is unable to satisfy the patient's needs for nourishment, clothing, essential medical care, or shelter so that it is likely that the person will suffer physical injury, physical debilitation, or death. *Iowa Code 229.1 (16).*
Massachusetts	No specific "gravely disabled" provision, but "likelihood of serious harm" includes "a very substantial risk of physical impairment or injury to the person himself as manifested by evidence that such person's judgment is so affected that he is unable to protect himself in the community and that reasonable provision for his protection is not available in the community. *Mass. Gen Laws ch. 123 §1.*

State Approaches to Defining Gravely Disabled in Civil Commitment Laws	
New Mexico	"Grave passive neglect" means failure to provide for basic personal or medical needs or for one's own safety to such an extent that it is more likely than not that serious bodily harm will result in the near future. *N.M. Stat. Ann. 43-1-3(K).*
Oregon	No specific "gravely disabled" provision, but "mentally ill person" includes a person who, because of a mental disorder, is one or more of the following: … (B) Unable to provide for basic personal needs and is not receiving such care as is necessary for health or safety. (C) A person who: (i) Is chronically mentally ill ….; (ii) Within the previous three years, has twice been placed in a hospital or approved inpatient facility by the department …; (iii) Is exhibiting symptoms or behavior substantially similar to those that preceded and led to one or more of the hospitalizations or inpatient placements …; and (iv) Unless treated, will continue, to a reasonable medical probability, to physically or mentally deteriorate so that the person will [become a danger to themselves or others or be unable to provide for their basic personal needs]." *Or. Rev. Stat. § 426.005(1)(d).*

Of the comparison States, Arizona, Colorado, and Oregon – like Washington – permit civil commitment even when a person's essential needs, such as food and shelter, are met. The Treatment Advocacy Center, a national advocacy organization that generally supports broader civil commitment criteria, estimates that half of the States have this kind of statute permitting commitment when there is a "need for treatment."[24] Each of these States, however, imposes different criteria regarding when a person may be civilly committed under these circumstances.

For example, Arizona's relatively broad statute requires a person to have a severe mental disorder that, if not treated, has "a substantial probability of causing the person to or continue to suffer severe and abnormal mental, emotional or physical harm that significantly impairs judgment, reason, behavior, or capacity to recognize reality." In addition, the person must not be capable of making an informed decision regarding treatment, and the person's disorder must have "a reasonable prospect of being treatable."

In contrast, Oregon permits civil commitment for individuals who have prior hospitalizations and are exhibiting symptoms similar to those that led to earlier hospitalizations, but further requires a showing that, unless treated, the person will continue, "to a reasonable medical probability," to deteriorate until he or she is either a danger to himself or others or unable to meet essential needs.

Iowa, Massachusetts, and New Mexico do not permit civil commitment unless a person is unable to meet his or her essential needs which, in Massachusetts, means that the person is unable to protect himself in the community. The approach used in each of these States generally permits civil commitment only when the person's condition poses a danger to

[24] See Treatment Advocacy Center, *State Standards for Assisted Treatment* at www.psychlaws.org.

self or others, including the danger that could result from an individual's inability to meet his or her essential needs.

Strengths

Washington's definition of "gravely disabled" effectively addresses the specific concerns that led to its revision in 1979. Specifically, the statute permits the civil commitment of people who are experiencing a severe deterioration in functioning and who are not receiving care essential for their health or safety – even if other essential human needs are being met. This is an important concern for many family members who want to ensure that their loved ones receive treatment before they pose a danger to themselves or others.

Other stakeholders have suggested that a broader law permits more flexibility to address individual needs on a case-by-case basis. For example, one King County prosecutor told the authors of this report: [25]

> A common theme here is that even though the grounds for commitment are present, a DMHP does not necessarily need to detain. However, if you shrink the available grounds for commitment, a DMHP will be unable to detain, even when the need to detain is great.

Challenges

Washington's statutory definition of "gravely disabled" is broader and, on its face, permits civil commitment under more circumstances than in most States. As discussed in Section IV, it is not clear how the breadth of statutory definitions and civil commitment criteria affects rates of civil commitments in any given State, but it is reasonable to assume that narrowing the law may lead to a reduction in the number of commitments and related inpatient admissions.

Options for Reform

Several State examples provide options for reforming the definition of "gravely disabled" within Washington's civil commitment statute:

1. **Repeal 71.05.020(16)(B).** One approach to reform would be to repeal the 1979 amendment to the statute that permits civil commitment, even when a person's essential needs such as food and shelter are met, if the person is experiencing severe deterioration in routine functioning and is not receiving care essential for his or her health or safety. Such an approach likely would be supported by many, but not all, consumers, advocates, and Protection and Advocacy and defense attorneys. Many other stakeholders, including families, police officers, prosecutors, providers, and DMHPs likely would oppose such a change, arguing

[25] E-mail correspondence from Ethan S. Rogers, Jr. Senior Deputy Attorney, ITA Unit – Civil Division, King County Prosecuting Attorney's Office (Feb. 23, 2007).

that this would delay intervention and treatment, with negative consequences both for the individual and community safety.

2. **Modify 71.05.0200(16)(B).** Several possible amendments to the gravely disabled definition could help to narrow the law while still permitting commitment before a person poses a danger or is unable to care for themselves. These include:

    - **Narrowing the law to permit civil commitment only when the person is unable to make their own informed judgment about treatment.** Arizona's statute, for example, includes such a requirement.

    - **Including a requirement that the person's deterioration is likely to result in the person becoming a danger to themselves or others.** Although Oregon's statute permits civil commitment of a person before they become a danger to themselves or others, it requires a showing that, "to a reasonable medical probability," the deterioration will continue until the person meets other statutory civil commitment criteria.

    - **Including a requirement that the person's deterioration is likely to result in the person requiring hospitalization.** Oregon's statute permits civil commitment where a person has been previously hospitalized and is exhibiting behaviors and symptoms similar to those that resulted in prior hospitalizations.

C. Implications for Reform

Stakeholders participating in research for this project expressed significant concerns regarding how reforms to the State's civil commitment laws would affect people needing mental health services and implications for existing service systems. Many stakeholders noted that community and State hospitals have provided a safety net for people who are not adequately served in the community and, while that may not be desirable, statutory reform that would result in reducing the number of people who can be detailed or civilly committed would leave an immediate gap in access to services for people who need them.

For example, one focus group participant noted that there are few options for long-term care in the community for people with dementia or traumatic brain injury who may, as a result of their disorder, be assaultive or aggressive. Members of the STI Task Force and other stakeholders emphasized that any reforms to the involuntary treatment laws must be coordinated with stakeholders from other service systems, especially those serving people with developmental disabilities, traumatic brain injury, older adults, and children, to enhance services provided through those systems.

At the May 15 Community Forum, stakeholders were asked whether they would support narrowing criteria for civil commitment and, if so, under what circumstances. Although more than three-fourths of the 127 people responding said they would support narrowing

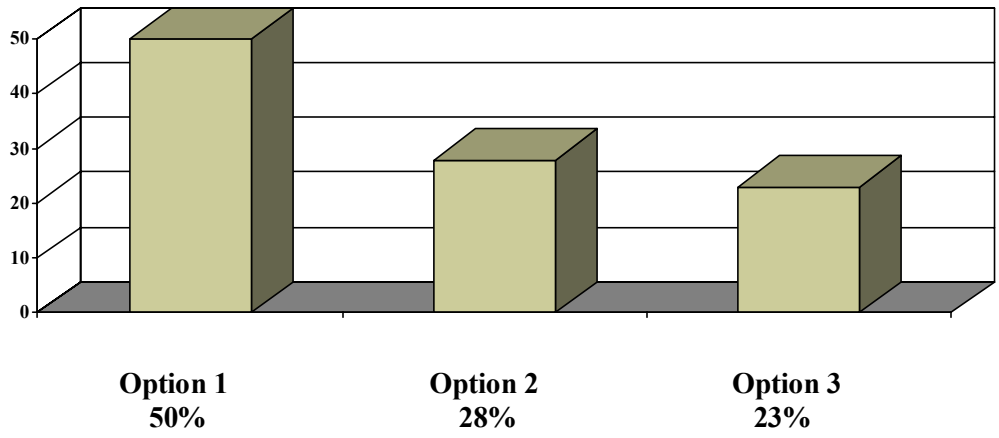
criteria under some circumstances, most of those said that they would support such a change only if needed community services and resources were in place first. The responses are summarized below at Figure 5:

Figure 5.

May 15 Community Forum Audience Response System:

Please select the statement that best reflects your own view:

1. I would support narrowing criteria for civil commitment, but only if needed community services and resources were in place first.
2. I support narrowing criteria for civil commitment as a first step, with the belief that statutory change will motivate the state to create a more effective community-based, recovery-oriented deliver system.
3. I would not support narrowing criteria for civil commitment under any circumstances.



Several stakeholders who support reform, especially those who believe that the definition of "mental disorder" should be modified, suggested that a "cross-system response" is needed to ensure that people who have developmental disabilities, traumatic brain injury, or dementia receive needed crisis services in the community as an alternative to hospitalization. They pointed to recent initiatives within Washington State to develop a cross-system crisis response to better meet the needs of people with co-occurring mental health and substance use disorders as a possible model for such an approach.

VI. Age of Consent and Parent-Initiated Treatment for Minor Children

This section provides an overview of concerns related to the age at which minors may consent to mental health treatment ("age of consent") and parent-initiated treatment, including an analysis of the statutory text, a summary of stakeholder concerns, and a discussion of additional research to be completed for the final report. Although this discussion is informed by examples from other State laws, a formal review of comparison States is not used to conduct the analysis.

A. Overview of Issues and Analysis

In Washington, a minor 13 years or older may admit themselves to an evaluation and treatment facility for inpatient treatment without parental consent.[26] If the professional person in charge of the facility agrees that the minor needs inpatient treatment because of a mental disorder, the facility provides the type of evaluation and treatment needed, and it is not feasible to treat the minor in a less restrictive setting, the minor may be admitted.[27] A minor who initiates inpatient treatment in this way may give written notice of intent to leave at any time and, in general, must be discharged from the facility at that time.

Similarly, a minor 13 years or older may request and receive outpatient mental health services without parental consent.[28] The law requires parental notification when a minor is admitted to an inpatient facility and when he or she is discharged, but notification is not required when the minor receives outpatient services at his or her request.

Washington is not unique in permitting teenaged minors to request and receive mental health services without the consent of the minor's parent. Several States give minors the explicit authority to consent to outpatient mental health services. None of these States specifically requires parental consent to obtain these services, and many do not generally require parental notification. Some States, such as California[29] and New Mexico,[30] permit minors as young as 12 years old to consent to mental health treatment. Several States, such as Connecticut, permit minors 14 years and older to consent to treatment.[31]

Many Washington stakeholders, especially parents' advocates, have suggested that the age of consent is too low. For example, NAMI-Washington's formal position is that the age should be increased.[32] However, most stakeholder concerns seem to focus principally on a minor's right to *refuse* treatment that their parents and treatment providers believe they need, rather than a minor's right to *access* treatment without their parent's consent. At the May 15 Community Forum, participants were asked to indicate

[26] RCW §71.34.500.
[27] Id.
[28] RCW §71.34.530.
[29] Cal. Civ. Code §25.9.
[30] N.M. Stat. Ann. §32A-6-12.
[31] Conn. Gen. Stat. §17-205f.
[32] Telephone interview with Gordon Bopp and Betty Scott, May 3, 2007.

whether they thought teenagers (ages 13-17) were mature enough to make their own decisions about receiving mental health treatment, refusing mental health treatment, or both. Of the 124 stakeholders who responded, the majority of stakeholders agreed that teenagers should be able to seek and receive treatment without their parents' knowledge or permission, but should not be able to refuse treatment that their parents and treatment providers feel they need. The responses are summarized below at Figure 6:

Figure 6.

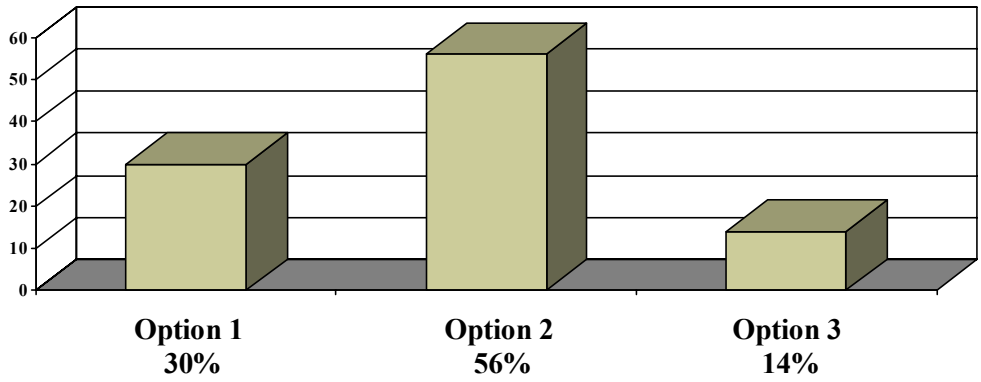
May 15 Community Forum Audience Response System:

Please select the response that best represents your own view:

1. Teenagers (ages 13-17) should be able to make their own decisions about mental health care and should be treated against their will only if the meet the same civil commitment criteria as adults.

2. Teenagers should be able to seek and receive both inpatient and outpatient mental health services without their parents' knowledge or permission, but they should not be able to refuse treatment that their parents and treatment providers feel they need.

3. Teenagers are not yet mature enough to make decisions about their own mental health care, and parents, in collaboration with clinicians and other treatment providers, should be the final decision-makers regarding their treatment.



The Washington legislature attempted to address these concerns directly with adoption of a statute permitting "parent-initiated treatment" of a minor child of any age. This law (RCW §71.34.600) permits a parent to take his or her minor child to an appropriately licensed facility (as defined by statute) and request that the minor be examined to determine whether he or she has a mental disorder and is in need of inpatient treatment.[33] If the parent takes the minor to the facility, the minor's consent is not required for admission, evaluation, and treatment. An evaluation should be completed

[33] RCW §71.34.600.

within 24 hours, although that time period may be extended for a total of 72 hours if the professional person[34] conducting the evaluation believes additional time is necessary.

It is important to note that a minor admitted to an inpatient facility through this parent-initiated process is considered a voluntary patient, whether or not the minor objects to the admission. As a result, the standard for admission is whether the minor has a mental disorder and whether he or she is in need of treatment and the admission is medically necessary. There is no requirement that the minor pose a danger to self or others or that he or she be gravely disabled. In addition, the statute specifically provides that, while a provider is not required to conduct an evaluation or admit a minor under this parent-initiated process, the provider may not refuse to provide treatment solely because the minor objects. Similarly, the minor may not be discharged solely on the basis of his or her request.

Despite the statutory provision permitting parent-initiated treatment, stakeholders contacted in connection with research for this preliminary report generally said that the process is not used. This is consistent with legislative findings in 2005, which stated: [35]

> The legislature finds that, despite explicit statements in statute that the consent of a minor child is not required for a parent-initiated admission to inpatient or outpatient mental health treatment, treatment providers consistently refuse to accept a minor aged thirteen or over if the minor does not also consent to treatment. The legislature intends that the parent-initiated treatment provisions, with their accompanying due process provisions for the minor, be made fully available to parents.

The legislature also amended the statute, apparently to address provider concerns about legal risk or liability, by adding the following section:[36]

> A minor child shall have no cause of action against an evaluation and treatment facility, inpatient facility, or provider of outpatient mental health treatment for admitting or accepting the minor in good faith for evaluation or treatment under [the parent-initiated treatment provisions of the statute] based solely upon the fact that the minor did not consent to evaluation or treatment if the minor's parent has consented to the evaluation or treatment.

It is not clear why the parent-initiated treatment provisions of the statute are not more widely used. One possible reason may be a concern by providers about independent reviews of their admission decisions. The statute provides that DSHS review all parent-initiated inpatient admissions within seven to 14 days of the date that the minor was brought to the facility. The statute explicitly provides that the person conducting the

[34] Professional person is defined by the statute to mean a physician or other mental helaht professional empowered by an evaluation and treatment facility with authority to make admission and discharge decisions on behalf of the facility. RCW §71.34.010(18).
[35] RCW §71.23.600, *Finding – Intent* – 2005 c 371 §1.
[36] RCW §71.05.660.

review may not be affiliated with the facility or have a financial interest in continued inpatient treatment of the minor. If the reviewer does not agree that it is a medical necessity for the minor to receive inpatient treatment, the facility and parents will be notified and the minor must be discharged to his or her parents within 24 hours of their receipt of notice. Inpatient providers did not identify this review process as a source of concern during focus groups and key informant interviews conducted to date. However, it may be one reason that providers are reluctant to admit minors referred under the parent-initiated treatment provisions of the statute.

A second possible explanation, identified by several providers as a specific concern, is a lack of clarity regarding what treatment can be provided to minors who are admitted over their objections under this statute and the legal process available to minors who object to admission and treatment. Under the statute, a minor who is admitted for evaluation or treatment has the right to petition the Superior Court for release from the facility and must be informed of that right prior to the DSHS review.[37] Although the statute provides a time frame for the petition – not sooner than five days following the DSHS review – no additional guidance regarding due process afforded the minor is provided. Representatives for some inpatient providers have suggested that this lack of specific direction regarding process deters them from admitting minors, since there is insufficient clarity about how minors can exercise their rights and the obligations of providers to facilitate this.

In key informant interviews and focus groups conducted in connection with this project, many parents and parent advocates expressed frustration that providers do not adequately involve parents in the development and implementation of treatment plans for their minor children. Providers noted that minors who are legally able to seek and receive services have a right of confidentiality in their treatment records, although there is no legal bar to sharing information with the minor's consent. It is not clear from the anecdotal evidence received whether minors generally are encouraged to involve their families in treatment planning.

B. Options for Reform

One option to address parents' concerns would be to simply increase the age of consent to mental health treatment, but consequences of this approach may include dissuading some minors from seeking treatment. To minimize negative consequences, Washington should consider other, more limited approaches that would have the intended effects of ensuring that minors receive needed treatment, parents are appropriately involved in their treatment plans, and minors receive treatment that is medically appropriate and consistent with the minor's legal rights. To accomplish this, more research is needed to determine (1) why parent-initiated treatment, as permitted under current statute, is seldom used; and (2) whether parents could be more involved in the development and implementation of treatment plans for their minor children consistent with current law.

[37] RCW §§71.34.600(6), 72.34.620.

The Washington State Legislature recently authorized establishment of a new children's mental health evidence-based practice institute at the University of Washington Division of Public Behavioral Health and Justice Policy, and directed the institute to review current practices to determine the percentage of cases in which parents are engaged by treatment providers and the extent to which they are actively involved in the treatment of their minor children.[38] This study may provide an opportunity to conduct the needed research described above.

[38] Second Substitute House Bill 1088, filed May 10, 2007 (effective July 22, 2007).

VII. Forensic Issues and Concerns Related to the ITA

A significant number of people who are civilly committed in Washington State began the commitment process through the criminal justice system. Although an extensive review of this issue is outside the scope of this preliminary report, the implications are significant for the ITA. Therefore, a brief overview of the law, issues, and current efforts to address them is provided here.

Criminal laws related to people with mental illness are provided at RCW §10.77. Under that chapter, if there is reason to doubt the competency of a defendant in criminal court, the court, the defendant, or the prosecutor may order a competency examination. The court may, but is not required to, order that the examination take place in a hospital or other appropriate mental health facility. An inpatient examination must be completed within 15 days of the defendant's admission to the facility.

If the defendant is found not to be competent, the court may be required under the statute to detain them for competency restoration:

- If the defendant is charged with a felony, they will be detained for evaluation and treatment until they regain the competency necessary to understand the proceedings against them, for a period of up to 90 days.

- If the defendant is charged with a misdemeanor and has (1) a history of one or more violent acts, or a pending charge of one or more violent acts; or (2) was previously acquitted by reason of insanity or was previously found incompetent under §10.77 or any equivalent federal or out-of-State statute with regard to an alleged offense involving actual, threatened, or attempted physical harm to a person, then they will be detained for a competency restoration period of up to 14 days plus any unused time from the 15-day competency examination period.

If, at the end of the competency restoration period, a defendant who is charged with a misdemeanor still is not competent to stand trial, the court must order them detained for a period of up to 72 hours for the purposes of filing a civil commitment statute under §71.05. This process is known in Washington State as "forensic conversion."

Implementation of §10.77 is directly related to civil commitment under §71.05 in several ways, and reform of either law must be undertaken only with careful consideration as to how any changes will affect people who may be referred for civil commitment under either law. In particular, many stakeholders believe that a narrowing of civil commitment criteria under §71.05 may lead to an increase in the number of people who are arrested for misdemeanors because police officers may feel that the criminal justice system provides a more accessible avenue for people to receive help.

Stakeholders have identified several important issues related to the statutory text of §10.77 and implementation of the competency to stand trial and "forensic conversion" processes in Washington State. A few of these issues are described briefly below:

- **Use of Prior History.** At least one prosecutor commented on the difficulty of determining whether or not a defendant charged with a misdemeanor has a history of one or more violent acts that would require mandatory detention for competency restoration. Whether or not a person has committed a violent act is not always apparent from a review of their criminal record, and often requires additional research into the facts underlying previous charges. This may contribute to process delays that result in people with mental illnesses remaining in jail longer than is needed.

- **Timelines for conducting competency examinations.** The statutory language regarding the timeframe during which a competency examination must take place is vague when the examination takes place in jail, as most examinations for misdemeanants do. Jail officials and judges in King County have complained that defendants may wait for days or even weeks for an examination.

- **Content of the competency examination report.** Section 10.77.060(3) requires the competency examination report that is submitted to the court to include all of the following components:

    1. A description of the nature of the examination;
    2. A diagnosis of the mental condition of the defendant;
    3. If the defendant has a mental disease or defect or is developmentally disabled, an opinion as to competency;
    4. If the defendant has indicated his or her intention to rely on an insanity defense, an opinion as to the defendant's sanity at the time of the act;
    5. When directed by the court, an opinion as to the capacity of the defendant to have the requisite state of mind that is an element of the offense charged; and
    6. An opinion as to whether the person should be evaluated by a DMHP for civil commitment under §71.05 and as to whether the defendant is a substantial danger to other persons or presents a substantial likelihood of committing criminal acts jeopardizing public safety or security.

  The content of the competency examination report is one of several issues currently under review by a work group comprised of judges, prosecutors, defense attorneys, jail officials, and advocates from King County, along with representatives of the State Hospitals and MHD. At a December, 2006 meeting of this work group, most participants agreed that much of the information required in the competency examination report is not directly relevant to an initial finding of competency. There was a general consensus among participants that the requirements for the report should be streamlined in order to speed up competency determinations and reduce the amount of time that people with mental illnesses are required to wait in jail. Working with an outside consultant engaged by MHD, this group is developing recommendations for MHD regarding ways to accomplish this.

- **Mandatory competency restoration for misdemeanants.** Several stakeholders expressed dissatisfaction with the statute's requirement that a defendant with a history of one or more violent acts who is charged with a misdemeanor must undergo attempts at competency restoration, even if the crime they are charged with is not serious.

  In 2005, the Washington Supreme Court also struggled with this issue. In Born v. Thompson,[39] the Court applied a balancing test of interests to determine what the appropriate standard of proof should be in order to commit a person for competency restoration. The court found that, in the case of a misdemeanor crime for which penalties are relatively light, the court's interest in bringing the defendant to trial and the public safety interests were not strong. The court said that, in the case of people charged with misdemeanors, "[t]he individual liberty interest at stake here weighs more heavily in balance than the governmental interests in public safety and prosecution of misdemeanors." This imbalance was compounded, the court said, by a significant risk of an erroneous deprivation of liberty.

- **Length of competency restoration period**. Some State hospital staff and attorneys involved in the competency restoration process noted that the time period allowed for competency restoration for misdemeanants –14 days plus any unused time from the 15-day competency examination period – often is not adequate to bring someone to competency. Most suggested simply eliminating the restoration requirement for misdemeanants. Some stakeholders suggested lengthening the maximum restoration period with the goal of restoring more people to competency before they are referred for a civil commitment evaluation, but others noted that this likely would increase forensic utilization of State hospitals.

  Other stakeholders have observed that many individuals regain competency in less than 14 days but remain in the State hospital until the competency restoration period expires. Legislation recently adopted in Washington State, known as Senate Bill (SB) 5533, clarifies that mental health professionals may return individuals to court *at any time* if they determine that the individual's competency has been restored or that the individual will not regain competency.[40]

- **Location of competency restoration efforts.** In Washington State, virtually all competency restoration efforts for misdemeanants take place in State hospitals. This is not required by statute; §10.77.090(1)(d)(i)(C) provides only that competency restoration for misdemeanants take place "at a secure mental health

[39] Born v. Thompson, 117 P.3d 1098 (Wash. 2005).
[40] Substitute Senate Bill 5533, filed May 10, 2007 (effective July 22, 2007).

facility in the custody of [DSHS] or an agency designated by [DSHS] for mental health treatment and restoration of competency."[41]

SB 5533 expands the range of possible locations for competency restoration of misdemeanants, permitting a court to order conditional release for up to 90 days for the purposes of mental health treatment and restoration of competency. This new law is consistent with an approach used in some other States. For example, Arizona specifically permits courts to order a defendant to undergo outpatient competency restoration treatment.[42]

The work group of criminal justice and mental health stakeholders described above currently also is reviewing this issue and plans to make recommendations regarding the range of appropriate locations for competency restoration for misdemeanants.

- **Competency process for juveniles**. Some stakeholders expressed concern that Washington does not have a separate competency process for juveniles. Currently, juveniles who are arrested for either felonies or misdemeanors and are found not competent to stand trial are referred for competency restoration treatment under the same process and timelines provided for adults.

  Only about half the States address juvenile competency by statute, and the content of those statutes varies significantly.[43] However, many juvenile competency legal experts recommend adoption of juvenile competency statutes that specifically address the unique clinical, developmental, and legal circumstances related to juveniles with mental disorders who are in the criminal or juvenile justice systems. Redding and Frost outline key elements of effective juvenile competency statutes, which should provide substantive standards for incompetence, procedural requirements for determining whether a juvenile is incompetent, and specific processes for competency restoration, if required.[44]

In its most recent session, the Washington State Legislature adopted Substitute Senate Bill 5533, which is designed to provide more opportunities for diversion of people with mental illnesses by police officers, either into crisis stabilization units, appropriate voluntary outpatient programs, or detention under §71.05. Diversion options are targeted for people who are charged with non-serious misdemeanors and who do not have a history of serious violent offenses. Although no new funding is provided, the new law

[41] This subsection was not changed by adoption of Substitute Senate Bill 5533, but the citation will change as a result of a reorganization of sections of §10.77 required by that legislation.
[42] Ariz. Rev. Stat. §13-4512.
[43] Twenty-five States and the District of Columbia have statutes regarding juvenile competency, although some of these statutes simply reference their State's adult competency statutes. Ten States, including Washington, are guided by case law regarding juvenile competence. Frost, L. and Volenik, A., *The Ethical Perils of Representing the Juvenile Defendant Who May Be Incompetent*, 14 Wash. U. J. of Law and Policy at 332 (2004), citing Redding, R. and Frost, L., *Adjudicative Competence in the Modern Juvenile Court*, 9 Va. J. of Social Policy and Law 353 (2001).
[44] *See* Redding, R. and Frost, L. at 368-371; *see also* Frost, L. and Volenik, A. at 333-335.

establishes a certification process for crisis stabilization units, which are defined as "a short-term facility licensed by [DSHS] … such as an evaluation and treatment facility or a hospital, which has been designed to assess, diagnose, and treat individuals experiencing an acute crisis without the use of long-term hospitalization."[45] Individuals detained in a crisis stabilization unit must be examined by a mental health professional within three hours, and may be detained for up to 12 hours.

[45] New section 71.05.020(6), effective July 22, 2007.

VIII. Tribal Concerns, Analysis, and Options for Reform

A. Overview of Relationships Between MHD and Sovereign Tribes

The relationship between the government agencies of Washington State and the 29 Federally-recognized Tribes located within the State is governed by the Centennial Accord, which provides a framework for government-to-government relationships between the State and each sovereign Tribe. Although the Accord was initiated by the Governor of Washington State, it also recognizes the authority of the "chief representatives of all elements of state government" to ensure complete and broad implementation of the arrangement. The Mental Health Division (MHD), as part of the Department of Social and Health Services (DSHS), thereby maintains a direct working relationship with each of the 29 Tribes pursuant to the Centennial Accord.

While the primary relationship is between the State and each sovereign Tribe, essential relationships have formed between various agents acting on behalf of the State of Washington – including RSNs, Designated Mental Health Professionals (DMHPs), and State-operated treatment facilities such as the State hospitals and Children's Long-Term Inpatient Program (CLIP) facilities – regarding day-to-day implementation of provisions of the State's involuntary treatment laws.

Tribal members are able to access mental health services through multiple systems, including their own dedicated Indian Health Service (IHS) and Tribally-administered 638 facilities (funded by Title I or III of the Indian Self Determination and Education Assistance Act – Public Law 93-638), the Medicaid Prepaid Inpatient Health Plans (PIHPs) administered by the RSNs, or a combination of these systems. Coordination across these systems is supported by the 7.01 planning and policy development process, through which an Updated Report is renewed every two years to coordinate the efforts of DSHS overall, MHD, and the RSNs. Each of the 13 RSNs contracting with MHD are also required to carry out 7.01 planning processes at a local level with the Tribes located in their geographical boundaries.

B. Methodology and Approach

In developing this chapter, the report authors relied on multiple sources of information. First, input was sought directly from representatives of Tribal Governments, Recognized American Indian Organizations (RAIOs), and DSHS Indian Policy and Support Services (IPSS) managers. Initial input was obtained through a Tribal Forum held in February 2007.

Based on input from that Forum, two focus groups involving a broader representation of Tribal Governments, RAIOs, and IPSS managers were carried out in April 2007. One group was held in eastern Washington at the American Indian Health Center in Spokane. The group involved representatives from Colville Confederated Tribes, Kalispel Tribe, and Confederated Tribes of the Yakama Nation; five representatives from RAIOs; and two IPSS staff. The second group was held in western Washington and involved the

Tribal Chairman of the Stillaguamish Tribe; representatives of seven other western Washington Tribes, including Makah Nation, Puyallup Tribe, Shoalwater Bay Tribe, Skokomish Tribe, Stillaguamish Tribe, Tulalip Tribe, and Upper Skagit Tribe; and two IPSS staff. A complete listing of focus group participants is included in Appendix A of this report.

In addition, the authors conducted interviews with DSHS and MHD Tribal Liaisons and interested focus group participants. The authors also conducted additional targeted research regarding how two other States – Arizona and New Mexico – coordinate involuntary treatment with Tribal governments within their geographic boundaries.

C. Key Issues and Concerns

Consistent with the perspectives of stakeholders interviewed for the broader study, Tribal representatives emphasized that a lack of adequate community-based resources too often leads to involuntary treatment for adults and the need for children to be served in residential settings far from their homes and communities. In particular, Tribal stakeholders suggested that Tribal providers are in the best position to know and meet the specific needs of Tribal members but often lack adequate resources to provide mental health and other essential services directly. Tribal representatives noted that many Tribal programs are effective in preventing people from needing to access RSN services, and they suggested that the State should provide funding directly to Tribes to support these programs.

Tribal representatives also pointed to a general lack of coordination between RSNs and Tribes as a major concern. Although RSNs are required, through the 7.01 planning process, to develop Tribal collaboration plans, many Tribes said that these plans are not effectively implemented or adequately monitored by MHD. These Tribes said that the expertise of Tribal and RAIO mental health and broader human services staff often were not integrated into care decisions, resulting in Tribal members with mental illnesses failing to receive culturally competent services – or any services at all – until they are in crisis.

Tribal stakeholders also expressed specific concerns related to the involuntary treatment process itself, including the following:

(1) Lack of Tribal jurisdiction to detain an individual under the civil commitment laws or authorize inpatient services at State hospitals. In Washington State, if a Tribal court or provider identifies a person whom they believe requires involuntary treatment, the Tribe must contact the RSN in which the Tribe is located to request an assessment by a Designated Mental Health Professional (DMHP) for a determination regarding whether the person can be detained.

Some Tribes reported a smooth working relationship with DMHPs who generally agree to detain when recommended by Tribal providers or courts, but others said that DMHPs are not responsive to their requests and often make detention decisions with little or no

input from Tribal providers or representatives. According to one DSHS Tribal Liaison interviewed, a Tribe that contacts a DMHP to request a 72-hour detention may or may not succeed in having the DMHP even agree to conduct an assessment, depending on the Tribe's relationship with the RSN. The dependence on non-Tribal DMHPs can also result in delays in access due to travel, particularly in eastern Washington, where waits of eight hours or more were noted given the distances involved.

Formal DMHP Protocols provide only general guidance to DMHPs regarding detention of Tribal members. Protocol 135 of the 2005 Protocol Update provides:

> DMHPs should consult with the county prosecuting attorney regarding any interlocal agreements between the RSN and tribal governments. Tribal governments have authority over activities on Federally recognized tribal reservations. Individual RSNs are currently in the process of developing interlocal agreements with tribal governments on the conditions and procedures for conducting ITA investigations and detaining American Indians on tribal reservations.

In focus groups conducted in connection with this report, many Tribal representatives said they were not aware of any formal agreements or protocols between their Tribe and the relevant RSN for contacting and working with DMHPs.

(2) Lack of communication between Tribes and RSNs during involuntary treatment and discharge. Many Tribes noted that, when a Tribal member is detained under the involuntary treatment law, he or she is transported to a community hospital operated by non-Tribal providers for an evaluation. If the hospital petitions for a longer commitment period, the Tribe will not be engaged either in that process or in any subsequent legal processes related to the commitment. More important, according to some Tribal representatives, Tribes generally are not notified when a Tribal member is admitted to a State hospital, nor are they given an opportunity to be engaged – in contrast to RSNs – in planning for discharge. This lack of communication distances the individual from the natural and community supports that the Tribe provides and results in fragmented, uncoordinated services when the person is discharged.

(3) Need for direct negotiations between Tribes and the State. Although some Tribes reported having a functional, effective working relationship with their RSNs, all Tribes participating in focus groups agreed that they should have direct access to negotiations with the State regarding involuntary treatment. This is especially important because, while some Tribes may want to order detentions or civil commitment independent of RSNs and non-Tribal courts, others may lack the resources or clinical and legal capacity to do so. Tribal representatives emphasized that the Centennial Accord defines the relationship of Tribes to the State as a government-to-government relationship, and agreed that it was inconsistent with that agreement to require Tribes to negotiate with RSNs instead of the State.

C. Other State Approaches

The authors reviewed the approaches used in two other States – Arizona and New Mexico – regarding Tribal roles and responsibilities related to involuntary treatment. In Arizona, State mental health services are provided through Regional Behavioral Health Authorities (RBHAs), which operate much like Washington State's RSNs. Tribes in Arizona may elect to operate their own RBHAs (referred to as Tribal-RBHAs or T-RBHAs). Some Tribes operate T-RBHAs fully independent of the non-Tribal RBHA in their geographic service area, some operate partial T-RBHAs that directly oversee some services and coordinate others through the non-Tribal RBHA, and others rely fully on their non-Tribal RBHA.

Regardless of whether a Tribe has established a full or partial T-RBHA, Tribal courts and their representatives may elect to order detention and civil commitment directly or to rely instead on their RBHAs and the non-Tribal court system. Tribes in Arizona therefore have a choice about whether they want to collaborate with their regional State-designated mental health contractor and the scope of any collaboration undertaken, both for the initiation and provision of involuntary treatment, as well as for broader care provision.

Arizona statute defines the roles and responsibilities of both the State and the Tribe, ensuring that Tribal court orders are enforceable but allowing the attorney general five days to object to a civil commitment order:

> A. Notwithstanding any law to the contrary, an involuntary commitment order of an Arizona tribal court filed with the clerk of the superior court shall be recognized and is enforceable by any court of record in this state, subject to the same procedures, defenses and proceedings for reopening, vacating or staying as a judgment of the court. The Arizona supreme court may adopt rules regarding recognition of tribal court involuntary commitment orders. The state, through the attorney general, shall be given notice of the filing at the time the commitment order is filed and shall have five days from receipt of the written notice of the filing of the order to appear as a party and respond. A patient committed to a state mental health treatment facility under this section shall be subject to the jurisdiction of the state.[46]

Subsection B of the statute requires formal notification of the Tribal court before an individual committed by that court is discharged:

> B. Decisions regarding discharge or release of a patient committed pursuant to subsection A shall be made by the facility providing involuntary treatment. Ten days prior to discharge or release, the state mental health treatment facility shall notify the tribal court which issued the involuntary commitment order of the facility's intention to discharge or release a patient. Any necessary outpatient follow-up and transportation of the patient to the jurisdiction of the tribal court, within the time set forth in the notice, shall be provided for in an

[46] Ariz. Rev. Stat. 12-136-A.

> intergovernmental agreement between the tribe and the department of health services.[47]

In New Mexico, a single Statewide Entity (SE) is responsible for managing Medicaid and other publicly funded mental health services. In that role, the SE is required to establish direct linkages with Tribal courts, although the nature of those linkages is not prescribed by statute. The 2007 Statewide Behavioral Health Services Contract provides:

> The SE shall ensure that linkages with Tribal, Nation, and Pueblo Courts; IHS; Bureau of Indian Affairs (BIA); and Tribal, Nation, or Pueblo 638 programs are developed at the SE level and shall ensure that its subcontracted providers have established linkages with the preceding agencies in order to ensure appropriate coordination of care for Native American consumers utilizing those programs.[48]

In Washington State, RSNs are required to develop 7.01 collaboration plans with Tribes, but there is no requirement that these plans include linkages with courts or recognition of Tribal court orders.

D. Options for Reform

One option to address a common Tribal concern would be to allow Tribes to detain individuals independent of RSN approval. This could be accomplished by giving Tribes and Tribal Courts the ability to appoint Tribal DMHPs with authority to order involuntary treatment independently. RCW 71.05.020(10) defines a DMHP as "a mental health professional designated by the county *or other authority authorized in rule* to perform the duties specified in this chapter." This language suggests that DSHS could authorize Tribes to designate DMHPs without requiring a statutory change, so long as Tribal DMHPs meet all other statutory and administrative requirements.

Because Tribes vary significantly in their capacities to provide the needed clinical assessment and ensure due process protections for individuals who are detained, some Tribes may opt to designate a Tribal DMHP while others may choose to continue to coordinate with RSNs regarding detention. Allowing each Tribe to decide its own approach would be consistent with Tribal sovereignty as reaffirmed through the Centennial Accord and as reflected in other areas of mental health service delivery. For example, Tribes currently are able to access services through Indian Health Services, operate their own 638 facilities, or access services through RSN provider networks.

A second option would be to require RSNs to accept referrals for 72-hour detentions from Tribes, rather than, in the words of one focus group participant, "wasting resources" by engaging a DMHP to conduct an additional assessment. This could be negotiated directly by Tribes with RSNs or, consistent with the government-to-government relationship that Tribes have with the State, the State could impose specific requirements on RSNs with respect to Tribal referrals.

[47] Ariz. Rev. Stat. 12-136-B.
[48] 2007 Statewide Behavioral Health Services Contract, Section 3.16.M.

It is important to note that Washington State only recently consolidated decision-making authority and financial responsibility for involuntary inpatient services with RSNs. This structure ensures that involuntary treatment is used only as a last resort and serves as a check on unnecessary inpatient utilization. Therefore, a significant concern regarding the two options provided here is that the nexus between decision-making and financial responsibility for involuntary treatment would be broken, giving Tribes the ability to detain Tribal members while RSNs remain in the role of payer. Should Tribes be given the option of designating DMHPs or if RSNs are required to accept Tribal referrals, some mechanism must be established to ensure uniform accountability for the use of involuntary treatment and inpatient utilization. Consideration of these issues should occur in the context of other recommendations regarding the authority of Tribes to deliver mental health services, including recommendations in the Benefit Design report to explore options for allowing Tribes to directly operate RSN functions. Establishment of Tribal DMHPs could also raise new issues about whether detention criteria are applied uniformly and where evaluations during the 72-hour detention period would be conducted.

IX. Other Relevant Issues

This section provides a very brief overview of several additional issues that were identified by stakeholders or the authors during the initial research phase of this project. These issues fall outside the scope of this review but are relevant to Washington's involuntary treatment laws. Some of these issues suggest the need for additional research and/or statutory reform that may be addressed in other forums.

A. Involuntary Medication

Many consumers and advocates identified the involuntary administration of psychotropic medications under the ITA as their highest priority for reform. In particular, they expressed dissatisfaction with §71.05.215(1)(c), which permits the involuntary medication of a person receiving short-term treatment up to 30 days under a civil commitment order if there are two concurring medical opinions approving the medication. Legal experts in Washington representing both patients and hospitals agreed that the current law raises important constitutional questions.

There are a range of views regarding how this concern should be addressed – consumers suggest that the involuntary administration of medication should never be permissible unless supported by an advance directive, while some attorneys suggest that other State laws requiring hearings for the non-emergency administration of medications might provide models for reform. Despite these differences, however, the consensus that a significant issue exists suggests the need for further study and appropriate reform efforts.

B. Definition of Likelihood of Serious Harm

Washington's statute permits civil commitment of a person if there is a substantial risk that "physical harm will be inflicted by a person upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others."[49] Most States do not permit civil commitment on the basis of danger to property, and this represents a significant deviation from the usual criteria of "danger to self or others." This provision provides an opportunity for reform, although none of the stakeholders involved in the initial research for this project indicated that this was a priority for them. More research is needed to know how frequently this is a basis for detention and/or inpatient admissions.

C. Advance Directives

RCW Chapter 71.32 provides specifically for the development and implementation of mental health advance directives. Many consumers, families, and advocates pointed to advance directives as an important tool in reducing involuntary treatment, including both civil commitment and the involuntary administration of medication. Specifically, these stakeholders suggested that a more robust approach to encouraging and using advance

[49] RCW §71.05.020(21)(a)(iii).

directives would permit earlier intervention consistent with the person's own wishes, rather than relying on civil commitment and other involuntary treatment approaches. In addition, many consumers objected to a provision in the law providing that advance directives will not apply when a person is civilly committed under §71.05. More research is needed to identify barriers to the use of advance directives and options for implementing them under a civil commitment order.

D. Training for DMHPs

Although available data does not necessarily confirm that DMHPs vary in how they apply civil commitment criteria, several stakeholders – including representatives of RSNs and the State association representing DMHPs – observed that DMHP training varies significantly from RSN to RSN. Although MHD has established Statewide training protocols pursuant to §71.05.214 and provides a 40-hour basic training, the training is designed principally for new DMHPs and participation is not required. Participation in specific trainings provided by the State association representing DMHPs also is not required.

In general, RSNs serving larger populations provide independent training, but smaller RSNs have fewer available resources and the DMHPs in those areas generally are less experienced. More uniform training provided by the State should be considered to address concerns about variation in detention rates across RSNs.

E. Converting to Voluntary Status

A few stakeholders expressed concern about the ability of people who are detained under the involuntary treatment statute to convert their status and receive treatment on a voluntary basis.

Section 71.05.150 specifically provides that DMHPs may petition for an initial detention only if they have attempted to interview the person to determine if he or she will receive evaluation and treatment voluntarily. In addition, §71.05.230 provides that 14-day petitions may be filed only if "the person has been advised of the need for voluntary treatment and the professional staff of the facility has evidence that he or she has not in good faith volunteered." Despite these statutory provisions, however, some stakeholders suggested that inpatient providers are reluctant to permit people to convert to voluntary status. It is not clear how often this concern arises, although one public defender suggested that, in his experience, this is a significant problem.

There may be several reasons for inpatient providers to discourage patients from converting to voluntary status. For example, hospital representatives pointed out that once an individual becomes a voluntary patient they may refuse recommended treatment or request discharge against the advice of their physicians. In those instances, hospital representatives said, the patient has not volunteered "in good faith," as required by the statute. In addition, as a voluntary patient, the individual would not be able to be served in Western or Eastern State hospitals, so access to long-term treatment would be limited.

Because people discharged from State hospitals have priority to receive services through Program for Assertive Community Treatment (PACT) and the Extended Community Support program, this lack of access to State hospital inpatient services has implications that extend into the community.

Proponents of reform in the way that this law is applied disagreed that these reasons justify a provider's decision to refuse a patient's request to be converted to voluntary status. They noted that patients who convert to voluntary status and then request discharge from the hospital may be re-examined by a DMHP, who can petition for a second detention. They suggested that the right to convert to voluntary status is critical because it gives consumers more control over treatment decisions.

Appendix A

Key Informant Interviews

Gordon Bopp, President, NAMI-WA
Sarah (Sally) Coats, J.D., Washington Assistant Attorney General
Marilyn Deans, Western State Hospital
Deborah A. Dorfman, Washington Protection & Advocacy System
Mike Finkle, Assistant City Attorney Supervisor, City of Seattle
W. Lawrence Fitch, M.D., Director of Forensic Services, Maryland Department of Mental Hygiene
Linda Frost, Ph.D., J.D., Associate Director, Hogg Foundation for Mental Health, University of Texas at Austin
Dawn Grosz, Parent Coordinator, Statewide Action for Family Empowerment
Michael Haan, Mind Freedom
Judy Hall, Ph.D., Director of Research, DSHS Mental Health Division
Avreayl Jacobson, Tribal Liaison, DSHS Mental Health Division
Darcy Jaffe, M.N., A.R.N.P., Director of Inpatient Psychiatry and Psychosocial Consultation, Harborview Medical Center
David Kersey, M.D., Medical Director for Mental Health Services, Seattle Jail Health Services
Ira Klein, M.D., Medical Director, Western State Hospital
Ted Lutterman, Director of Research, NASMHPD Research Institute, Inc. (NRI)
Robin McIlvaine, Children's Issues Lead, DSHS Mental Health Division (and additional MHD staff representing children's team)
Deborah Moskowitz, Ombuds, North Sound RSN
Andy Phillips, Ed.D., Chief Executive Officer, Western State Hospital
Jill San Jule, Consumer Liaison, Washington's Mental Health Transformation Project
Amnon Schoenfeld, CEO, King County RSN
Betty Scott, NAMI-Washington
John Tauriello, J.D., Counsel, New York Office of Mental Health
Laura Van Tosh, Director of Consumer Affairs, Western State Hospital

Focus Group Participants

12/21/06 Focus Group
Ian Harrel
Richard Lichtenstadter
Ira Klein
David Johnson
Gordon Bopp
Diana Jaden-Catori
Michael Haan
David Reed
Darcy Jaffe
Ethan Rogers
Amnon Shoenfeld
Morgan Pate
David Lord
Jill SanJule

1/17/07 Meeting with Washington Behavioral Health Inpatient Association
Will Callicoat
Mike Kerlin
Darcy Jaffe
Ann Moore
Karla Gray
Linda Crome
Edie Herman
Jackie Karsh
Ginny Buford
Carols Carreon
Shirley Goodman

1/17/07 Focus Group at Western State Hospital
Laura Van Tosh
Four individuals currently civilly committed to Western State Hospital

2/5/07 Focus Group re: Tribal Issues – Tacoma
Helen Frenrich, Tulalip Tribe
Ric Armstrong, Quinault Tribe
Deb Sosa, American Indian Health Center
Jennifer LaPointe, Puyallup Tribe
Doug North, DSHS Indian Policy and Support Services
Sharri Dempsey, DSHS Indian Policy and Support Services
Carmelita Adkins, DSHS Indian Policy and Support Services
Avreayl Jacobson, DSHS MHD

2/15/07 Task Force Focus Group
S. Morgan Pate
Richard Lichtenstadter
Ann Christian
Rick Weaver
Eleanor Owen
Becky Bates
David Johnson
Amnon Shoenfeld
Ethan Rogers
Bill Wilson
BJ Cooper
Chuck Benjamin
Ken Stark
Dan Peterson

4/17/07 Focus Group re: Tribal Issues – Spokane
Joseph Waner, Kalispel Tribe
Gladys Yallop, Yakama Tribe
Linda Lauch, American Indian Community Center
Judy Johnson, American Indian Community Center
Sophie Tonasket; American Indian Community Center
Cindy Robinson, N.A.T.I.V.E. Project
Sarah Jamison-Jeter, N.A.T.I.V.E. Project
Phil Ambrose, DSHS Indian Policy and Support Services
Bob Brisbois, DSHS Indian Policy and Support Services

4/18/07 Focus Group re: Tribal Issues – Seattle
Doug Mayer, Makah Nation
Linda Thomas, Skokomish Tribe
Jeanne Paul, Shoalwater Bay Tribe
Adrianne Hunter, Upper Skagit Tribe
Shawn Yawity, Stillaguamish Tribe
Edward Reser, Stillaguamish Tribe
Jennifer LaPointe, Puyallup Tribe
Sheryl Fryberg, Tulalip Tribe;
Sharri Dempsey, DSHS Indian Policy and Support Services
Doug North, DSHS Indian Policy and Support Services

6/6/07 Focus Group with Eastern State Hospital staff – Via Conference Call
Johnny Williams, Ph.D., Director of Psychology
Alan Muhelstein, Ph.D., ITA Psychologist
Mark Kreilkamp, M.S.W., APU Psychiatric Social Work Supervisor/Placement Coordinator
Anita Cornell, A.C.S.W., Director of Social Work
Shirley Maike, Compliance Officer

Appendix B

Summary of Civil Commitment Process

The civil commitment process is described at RCW 71.05 and summarized below. An excellent discussion of the civil commitment process in Washington can be found at: Finkle, M.J. (2003). *An Introduction to the Mental Health Civil Commitment Law.* Prepared for the Snohomish County Bar Association, Everett, WA.

Petition for an initial detention. In Washington State, petitions for an initial detention generally are initiated by a Designated Mental Health Professional (DMHP). DMHPs are hired, employed, and often trained by Regional Support Networks (RSNs), which contract with the State to administer all public mental health services within their geographic region. The purpose of an initial detention, which can last for up to 72 hours, is to evaluate whether the individual meets specific civil commitment criteria. Currently, initial detentions generally occur in community hospitals and do not take place either at Western or Eastern State Hospitals.

Recent legislation, which will become effective July 22, 2007, attempts to give police officers authority to permit brief detentions as a way to divert people with mental illnesses from the criminal justice system. The new law also authorizes a new kind of facility – called a crisis stabilization unit – that may be used for this initial detentions.

Under the new law, there are two ways in which an initial detention can be initiated:

1. ***Emergent detention.*** If a person is believed to present an *imminent* likelihood of serious harm, or if he or she is in *imminent* danger because of being gravely disabled, the DMHP may have the person taken into emergency custody for up to 72 hours. If a police officer believes that a person meets these criteria, he or she may take custody and immediately deliver the person to a crisis stabilization unit, evaluation and treatment facility, or hospital emergency department for a period of up to 12 hours. In this case, the person must be examined by a mental health professional with three hours. If the person is determined to meet detention criteria, a DMHP must file a petition for detention within 12 hours.

2. ***Nonemergent detention.*** If the person is believed to pose a likelihood of serious harm or be gravely disabled but the danger or risk is *not* imminent, the DMHP may petition the Superior Court for the county in which the DMHP works for an order to detain the individual for a period of up to 72 hours. The judge may issue the order if he or she believes there is probably cause to support the petition and the person has refused or failed to accept appropriate evaluation and treatment voluntarily. The DMHP may notify a police officer to take the person into custody involuntarily.[50]

[50] This section reflects recent changes to the law enacted in Substitute Senate Bill 5533, filed May 10, 2007 and effective July 22, 2007.

Probable cause hearing. If the facility conducting the evaluation determines that the person meets civil commitment criteria, the facility may file a petition for either 14 days of inpatient treatment or 90 days of less restrictive alternative (LRA) treatment.

At a probable cause hearing on the petition, the facility (usually represented by county prosecutor) must demonstrate by a preponderance of the evidence that the person meets civil commitment criteria. The person has several rights at that hearing, including the right to participate in person, to present evidence, and to cross-examine witnesses. There are several possible outcomes of a probable cause hearing:

- If the court finds that the person meets civil commitment criteria, it must consider LRAs before ordering inpatient treatment. In determining whether LRAs are appropriate, the statute requires the Court to give "great weight" to evidence of a prior history or pattern of decompensation and discontinuation of treatment resulting in repeated hospitalizations or interactions with the criminal justice system. An LRA order generally will require some form of outpatient treatment within the community for up to 90 days.

- If the court determines that an LRA is not in the best interests of the person or others, it will order inpatient treatment of up to 14 days. In general, 14-day commitments take place in evaluation and treatment facilities and do not occur at state hospitals, although some 14-day commitments take place at Eastern State Hospital.

  The statute provides that if, during the 14-day period, the professional person in charge of the facility determines that the person no longer meets civil commitment criteria, or if the person agrees to accept treatment at the facility voluntarily, the 14-day inpatient commitment must end.

- If the court finds that the person does not meet statutory criteria for civil commitment, the person will be released.

Full hearing. At the end of the 14-day period, the facility providing treatment may petition the court for an extended period of commitment. That petition is filed in Superior Court for the county in which the person is located, even if that county is different than the county in which the 72-hour detention was initiated. At the hearing, the facility will again generally be represented by the county prosecutor, although if the facility is a state hospital, it will be represented by an attorney from the state Attorney General's office.

At the hearing, the facility must prove, by "clear, cogent and convincing evidence"[51] that the person meets civil commitment criteria. If the Court agrees, then the person may be civilly committed for up to 90 days of inpatient treatment. Most, but not all, treatment

[51] RCW §71.05.310.

under 90-day orders takes place at either Western State Hospital or Eastern State Hospital. As before, the court must consider whether an LRA is in the best interests of the person and others. If so, then the court must order 90 days of treatment in the community.

Subsequent orders. At the end of the 90-day period, the person must be released unless a renewal petition is filed by the facility in Superior Court for the county in which the person is being held (generally, either Pierce or Spokane County). The commitment period under this petition and all subsequent petitions is 180 days and the standard of proof and rights of the person are the same as at the full hearing. If the 90-day order was for an LRA, the DMHP may petition for continued treatment. If the Court does not renew the commitment order, the person will be released.

Early release and conditional release. A person who is civilly committed under a 90-day or 180-day order should be released if the professional person in charge of the treatment facility believes he or she no longer meets civil commitment criteria. In addition, the person may be "conditionally released" if the professional person in charge of the facility believes the person can be appropriately served by outpatient treatment. A conditional release requires notification to the Court that originally committed the individual and the DMHP in the county in which the person will receive treatment. The conditional release period may not exceed the period of the commitment order.